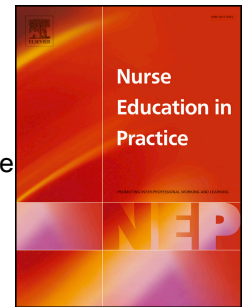


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MANIPULATING MENTORS' ASSESSMENT DECISIONS: DO UNDERPERFORMING STUDENT NURSES USE COERCIVE STRATEGIES TO INFLUENCE MENTORS' PRACTICAL ASSESSMENT DECISIONS?

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MANIPULATING MENTORS' ASSESSMENT DECISIONS: DO UNDERPERFORMING STUDENT NURSES USE COERCIVE STRATEGIES TO INFLUENCE MENTORS' PRACTICAL ASSESSMENT DECISIONS?

Abstract

There is growing evidence of a culture of expectation among nursing students in Universities which leads to narcissistic behaviour. Evidence is growing that some student nurses are disrespectful and rude towards their university lecturers. There has been little investigation into whether they exhibit similar behaviour towards their mentors during practical placements, particularly when they, the students, are not meeting the required standards for practice. This paper focuses on adding to the evidence around a unique finding – that student nurses can use coercive and manipulative behaviour to elicit a successful outcome to their practice learning assessment (as noted in Hunt *et al.* (2016, p 82)).

Four types of coercive student behaviour were identified and classified as: ingratiators, diverters, disparagers and aggressors, each of which engendered varying degrees of fear and guilt in mentors. The effects of each type of behaviour are discussed and considered in the light of psychological contracts. Mechanisms to maintain effective working relationships between student nurses and mentors and bolster the robustness of the practical assessment process under such circumstances are discussed.

Highlights

- Student nurses are expected to behave in a professional way towards others.
- Many student nurses exhibited coercive and manipulative behaviours when mentors told them that their practice did not meet the criteria required to pass their assessment.
- Four types of coercive student behaviour were identified and classified as: ingratiators, diverters, disparagers and aggressors, each of which engendered varying degrees of fear and guilt in mentors.
- A four pronged approach is recommended to assist mentors in managing coercive students: manage students' expectations, identify of the locus of the fail, recognition of coercive strategies, and support from official agencies.

Key Words

Practical assessment; narcissistic students; mentor resilience; coercive students; student nurse.

Introduction

Ensuring that an effective relationship exists between student nurses and their mentors is recognised as pivotal to a sound clinical experience. The United Kingdom Nursing and Midwifery Council (NMC 2008, p25) identify *"Establishing an effective working relationship"* as the first principle of learning and assessment in practice. For over thirty years it has been widely accepted that there is *"a galaxy of toxic mentors"* (Darling 1985, p43) who compromise such relationships and make students' practical experiences unpleasant or difficult (Darling 1986, Kilgallon and Thompson 2012, Stuart 2013, Clutterbuck 2014, Gopee 2015). However, the existence of such mentors is only one factor in managing students' learning; students themselves have parts to play in this and these may also negatively affect outcomes.

Concerns are now being raised about a culture of expectation being generated by universities where students are regarded as customers with rights and expectations and which encourages narcissistic behaviour in classroom settings (Twenge and Campbell 2009, Twenge *et al.* 2012, Twenge 2013, Vaillancourt 2013, Hodges 2015). The negative consequences of this situation, in terms of the behaviour of students towards their university lecturers, have been reported in other settings (Gallo 2012, Shanta and Ellason 2014). However, there has been little investigation into the possibility that students might behave negatively in clinical areas and, in particular, there appears to be limited examination of student nurses' responses to feedback that they are not performing to the required standards in practical assessments.

The main study, which followed previous work in this area (Duffy 2003 and 2006, Black 2011), demonstrated the overall factors which enabled mentors to fail underperforming student nurses in practical assessments (Hunt 2014, Hunt *et al.* 2016). As noted in the abstract the aim of this paper is to focus on adding to the evidence around a unique finding, regarding the coercive and manipulative behaviours student nurses employ to ensure a successful outcome to their practice learning assessment (as noted in Hunt *et al.* (2016, p82). A framework for classifying the types of behaviour that students exhibited towards mentors who gave them feedback about their lack of competence is presented and recommendations are made about actions which can enhance mentors self-assurance when students behave coercively or manipulatively, so that the integrity of the assessment process is not undermined.

The ideas presented here may be unthinkable to some in the nursing profession, and indeed prompted this expansion of the findings from this one theme (Hunt *et al.* 2016, p82). It was considered essential that the difficulties which coercive students can cause mentors are made evident and that a robust discussion about how to manage this is initiated so that such behaviour does not continue to flourish unchallenged.

Background

The young are four times as likely to show narcissistic personality traits as those over the age of sixty-five (Stinson *et al.* 2008) and this is considered a symptom of a western culture of entitlement (Twenge and Campbell 2009). Narcissistic personality traits include: an exaggerated sense of one's own importance; a belief in a right to unlimited success; an expectation of favourable treatment; a tendency to take advantage of others and a lack of empathy (Kernberg 1967, Kohut 1968). Overindulgent parenting and self-esteem focussed education systems are recognised as contributing to this (Twenge *et al.* 2012). It is suggested that, in the United Kingdom (UK), the National Student Survey (NSS 2015), a key league table by which universities are judged, may contribute to this culture of entitlement (Canning 2014). Universities are motivated to meet students' demands so that they rate highly in the NSS which improves their attractiveness to potential new students.

In the UK, practicing nurses act as mentors to student nurses during their practical placements. Mentors must have been a registered nurse for at least one year before they can undertake additional continuing professional development to prepare them to teach and assess students (NMC 2008). In other countries mentors are called preceptors, but in the UK the term preceptor is reserved for those who supervise recently qualified nurses who are consolidating their practice. Student nurses are allocated to a mentor at the beginning of a practical placement and work closely with them throughout in accordance with NMC guidelines (NMC, 2008, NMC, 2010). This process of managing learning can be further supported by colleagues with a higher level of teaching award, such as practice education facilitators or link lecturers.

Several studies have identified that mentors can be reluctant to fail underperforming students (Duffy 2003 and 2006, Black 2011) and that they need substantial support to do this. Nevertheless, much of the published literature focuses on the support students need in

practical placements. Scrutiny of mentors' performance suggests that they can, at times, display negative behaviour towards students including bullying (Topa *et al.* 2014, Hakojarvi *et al.* 2014), "*eating their young*" (Sauer 2013, p43) and exhibiting "*toxic*" traits (Darling 1986, p29, Clutterbuck 2014). There has been less scrutiny of students' negative behaviour. However, growing concerns about the incivility of student nurses towards staff in academic settings have been reported in the USA (Gallo 2012, Shanta and Ellason 2014). Some anecdotal evidence also exists about negative student behaviour towards mentors in clinical practice (Cleary and Horsfall 2010, Green and Jackson 2013)

In the UK patients have raised concerns that weak students try to manipulate the system to their advantage if they think they are going to fail and have been observed behaving badly towards their mentors (Malihi-Shoja *et al.* 2013). In 2009, in a keynote speech to the Royal College of Nursing Congress, Ann Keen, who was then health minister, warned students not to do mentors a disservice (Kendall-Raynor 2009). A survey by Nursing Standard also indicated that students could pressurise mentors into passing them (Gainsbury 2010) and Green and Jackson (2013) caution that mentors' experiences of students can be negative. These views are consistent with Passmore and Chenery-Morris's (2014) observations that midwifery students exert pressure on their assessors, and concerns expressed by Canadian nurses that students conceal damaging evidence about their performance (Luhanga *et al.* 2010). Evidence from the medical profession suggests that as doctors progress they increasingly struggle to acknowledge errors in their practice because they find this a challenge to their self-image of competence and control (Banja 2005). In social work this has been attributed to students' difficulty in objectively critiquing their own performance (Schaub and Dalrymple 2013) and the tendency to blame external forces (Poletti and Anka 2013). Furness (2011) noted that, when challenged about their practice, male social work students adopted a defensive stance. This evidence suggests that students can struggle to reconcile the service they expect to receive in a Higher Education Institution (HEI) setting with the standard of care they are expected to give in a care environment.

The Overall Study Design

The principle aim of the main PhD study was to investigate what enabled some mentors to fail underperforming students when it was recognised that many were hesitant to do so. However, as the study unfolded, as in many doctoral journeys, supplementary objectives emerged, with the eventual findings from theme three: "*Tempering Reproach*" being reported here (Hunt *et al.* 2016, p82).

Methodology

In order to illicit as much depth as possible to the research process and subsequent findings, this study employed an interpretivist grounded theory (GT) approach which explored shared meaning and activity (Corbin and Strauss 2008). This methodological approach was selected because it could provide explanations and offer recommendations for practical action. An overview of the method used is provided here, more details can be accessed in Hunt *et al.*'s 2016 publication and at: <http://ethos.bl.uk/OrderDetails.do?did=1&uin=uk.bl.ethos.639728> (Hunt 2014, full PhD study).

Accessing Participants

The study was publicised in 56 universities in England which offered pre-registration nursing programmes. Theoretical sampling techniques were used to recruit thirty one participants, who had voluntarily responded to this call to be engaged with the study. The main criterion was that all participants had to have failed a student in practice and each volunteer had experience of failing at least one student in a practical assessment. Contributors comprised mentors (MA), practice education facilitators (PEF) and link lecturers (LL) who all gave their written consent to participate. They represented the four fields of nursing in the UK, namely

adult, child, learning disabilities and mental health nursing, and worked in hospital and community locations, in both the National Health Service (NHS) and private sector (Table 1).

Ethical Issues

The ethical principles defined by Beauchamp and Childress (2013) underpinned the study design; the University where the PhD was being undertaken acted as sponsor and granted ethical approval (NHS Health Research Authority nd). Key information was provided to all potential recruits so they could make an informed choice about participating in the study. Confidentiality was maintained by assigning each nurse a specific code. A supportive resource detailing further available help was also provided. The option to withdraw from the study was built in.

Methods

The method followed a GT iterative process (Corbin and Strauss 2008). Semi-structured interviews were conducted using an interview schedule which was regularly updated to reflect emerging themes and probe gaps with subsequent participants. Interviews were recorded, transcribed and analysed. This process continued until categories were saturated.

Rigor was built into the process by using analytic sensitising tools (Corbin and Strauss 2008), these helped to examine conditions, circumstances, interactions, emotions, and consequences within the data. Field notes, memos and a reflective diary also enhanced conceptual thinking. These tools facilitated line by line coding of initial data and constant comparison with new incoming data. A paper based system rather than a computer package was chosen to analyse the data because it allowed concurrent viewing of a broader spectrum of data. Hand sorting codes, and memos helped to stay close to the data, whilst physically grouping these into categories managed the risk of becoming overwhelmed by the volume of information and suffering analytic paralysis (Clarke 2005).

Codes gradually amalgamated into conceptual groups which then combined into categories. The final explanatory framework which emerged was validated by: checking original data against the final abstraction, seeking participants' feedback, and checking the responses of others to ascertain transferability. Responses indicated that the taxonomy of coercive students has extremely strong resonance with mentors, evidenced by the numbers who have requested that these findings be published.

The findings being discussed here arose from Category Three: Tempering Reproach (see Hunt *et al.* 2016, p82) and are now discussed in depth.

Findings: Coercive and Manipulative Student Responses

Mentors indicated that students' responses to feedback about their performance had significant impact on them. Students could either respond by trying to improve their performance or reject the criticism and attempt to sway the assessment outcome by manipulating the mentor. Where students expected frank feedback, recognised that patients' needs superseded theirs, and knew that they should take responsibility for their own performance, they responded constructively as noted by this mentor:

"[The student] said, 'You haven't nagged me, what you've done is kicked my backside, so it's made me realise how much work I've needed to do.'" (MA05)

In such circumstances the mentor and student were able to work productively together to help improve the student's performance. This was considered a win/win situation in which both parties benefitted because the likelihood of a successful outcome for students increased and mentors also felt that they had fulfilled their obligation to be a 'good' mentor.

However, some students' behaviour became manipulative and the strategies they used ranged from gentle persuasion to malevolent coercion.

Four types of coercive students were identified; the names given to each group emerged from the language used by participants (Figure 1):

- Ingratiators
- Diverters
- Disparagers
- Aggressors

Each type of behaviour intensified mentors' guilt and fear to differing levels.

Ingratiators

Ingratiators were characterised as students who curried favour with their mentors by deliberate efforts such as being charming, obliging, indulging or emotionally exploitative. Mentors were susceptible to high levels of guilt and low levels of fear when students employed these tactics. Such students often had likeable personalities and worked to sway mentors by doing things to please them such as bringing in cakes and making cups of tea, running errands, offering compliments and flattery, or using persuasive emotional tactics like begging to be passed or overt demonstrations of emotion such as hugging or crying. One practice education facilitator (PEF) noted:

"The student will either try to be tearful, you know start crying or why, why, why have you got to fail me? And sometimes the student will pile on the pressure." (PEF01)

Such actions tested mentors' views of themselves as 'good' people who avoided causing harm, and open displays of emotion and distress particularly exploited their disposition to comfort and nurture. This further played on the mentor's guilt because they felt that they were causing harm to a pleasant person.

Diverters

Diverterers were depicted as students who attempted to distract and redirect the mentor's focus. Such students played on factors which were unconnected to the area of underperformance and could incorporate such elements as illness, personal circumstances, disability or on-going university proceedings. A mentor explained one such experience as follows:

"His personal problems, he'd already been told they shouldn't be impacting on his placement. For example, his washing machine had flooded, well that's got nothing to do with us. It was like my car broke down, I had to get a bus and taxi to work. So it was all irrelevant things that he knew shouldn't have an effect, he blew them out of all proportion." (MA04)

It was sometimes difficult for mentors to separate the relevant from the irrelevant in such circumstances. For example, a student who continued to spit in ward sinks, despite being given feedback about how inappropriate this was, informed her mentor that she could not be failed for this because she had a hearing impairment. In this case the mentor (MA08) was able to recognise that the one factor had no bearing on the other, but even in such situations students' disabilities or difficult personal circumstances could burden the mentor's conscience and this increased guilt. Alongside this, mentors could also be concerned that they might inadvertently have been unreasonable in their management and assessment of such students, and so anxiety also began to manifest itself.

Disparagers

Disparagers were described as students who challenged their mentor in belittling, denigrating or professionally harmful ways. The student could employ two methods. First, they might question the mentor's reasonableness and competence, or second, accuse the mentor of harassment, bullying or discriminatory behaviour. Mentors recognised that students had a right to raise these concerns:

“They’ve got the right to appeal against us if they think we’ve been unjust towards them.” (MA04)

However, they also pointed out that such counter claims could be used to distract attention away from the student’s under-performance.

In some instances guilt prompted mentors to question themselves deeply about their motives for raising concerns with the student. In such cases they preferred to blame themselves, as this PEF observed:

“As soon as the student starts to kick back they’ll back off and say ‘Oh you know it must have been me as a mentor’.” (PEF06)

Where disparaging strategies were used, mentors’ levels of fear increased as they became anxious that they would be identified as having shortcomings and would be in trouble, as this lecturer noted:

“It’s quite difficult because they fear that a student will turn around and say ‘Well you haven’t helped me.’” (LL05)

Mentors envisioned an ensuing investigation which might focus on their competence as a nurse and any weaknesses in their own practice, any failings in the way they had supported the student, or professional misconduct in terms of prejudice or intimidation. They feared this would damage their professional reputation, even if the claims were unfounded, as illustrated here:

“[Students] go back to the University and say what [I’ve] experienced there is a form of bullying or discrimination. Even if you know you haven’t done it, it can be quite detrimental.” (MA05)

Accusations of bullying and harassment were problematic for mentors because they had difficulty in discriminating between what might be considered thorough and conscientious

feedback and what might be seen as bullying and harassment. They felt that students were seldom exposed to frank critiques and so were not accustomed to this; consequently they were ill-prepared for criticism of their practice. Hence, a culture of expectation led students to believe they were entitled to succeed. This, coupled with the belief that a 'good' mentor could help any student to pass a practice based assessment, could result in students reacting defensively or counter-attacking to refute the criticism being levelled at them.

This behaviour occurred when the student believed the mentor had broken faith with them. It could lead to the mentor feeling they were being condemned by the student. Positions of resentment could arise, it became increasingly difficult to maintain a functional mentor/student partnership, and this often meant that the relationship broke down.

Aggressors

Aggressors were viewed as students who engaged in open hostility towards their mentor after negative feedback. Such students might threaten the mentor verbally or physically and do this directly or via a third party. Here are some examples which were talked about:

"I don't live locally and I came downstairs one day to find a hand written note on my doorstep, actually inside the porch from this student." (MA08)

"We had a student's boyfriend come and threaten the mentor because they'd said they were going to fail themEspecially when the partner came into the car park and threatened [the mentor] and he was supported, he was never left to go out of the building on his own, even in the day someone went to his car with him. " (MA13)

In such situations mentors experienced heightened fear but only limited guilt. These were the most extreme situations described by participants. In such cases mentors were deeply affected by the lengths to which students and their families/friends would go. When threats touched their home-life, mentors recognised the tenacity and courage they needed to see through the assessment of the student to its proper conclusion. However, they also noted

that their feelings of guilt subsided because the student's behaviour was so severe that the mentor's judgement of them was vindicated.

Recognising the Locus of the Fail

Having experienced such challenges, mentors who reached a point where they recognised that the student had failed by their own hand were the ones who felt the most secure. This was achieved through ensuring everything had been done to help the student and recognising both the student's responsibility within the assessment process and the reasonable expectations they, the mentor, should have of both the student and themselves. Practice education facilitators and link lectures were deeply valued when they helped mentors to reach this conclusion, as emphasised here:

"The god-send! Without her we wouldn't have [failed the student]." (MA04)

When mentors saw that they could not have done any more, and that the student's fate was in their own hands the onus shifted and self-reproach eased.

"It's not down to the mentor; it's actually down to the student that they failed. You've done more because you're working beyond and over really aren't you because you're trying your best to pass them." (MA01)

Mentors felt that, if they kept their side of the contract, the failing student should accept that it was their own performance that had not met requirements. Adjusting to this perspective absolved the mentor of much of the guilt they had experienced and increased their resilience to manipulative students.

Discussion

Mentors and students seem to have to negotiate a complex array of conflicting psychological contracts in circumstances where a student is not performing to the required standard in

practice (Rousseau 1989). A psychological contract (PC) is a tacit reciprocal agreement between an individual and another party which is built on perceptions of the promises and obligations each expects the other party to fulfil (Zagenczyk *et al.* 2009). The psychological contract has two facets, transactional expectations which are usually explicitly expressed, and relational expectations which are more often implicit and so open to individual interpretation (Chaudhry and Shapiro 2010).

The term psychological contract has recently been applied to both the professional/profession relationship (George 2009) and the mentor/mentee relationship (Haggard and Turban 2012). In this study the psychological contract between the student and the mentor centres on a shared agreement that a 'good' mentor should be able to help every student pass their practical assessments. Initially both parties seem to share the same perception. However, when a student consistently underperforms and is given this feedback by their mentor the psychological contract is perceived to have been broken and this has a number of consequences.

There are indications in this study that the student's previous socialisation into university culture influenced the assumptions they made on entering the practice environment. If the student had developed an explicit (transactional) psychological contract with the university in which they were encouraged to believe that they were the customer, then their education was the principal aim and their satisfaction took priority. It could be said that students expected mentors to uphold this contract. When the mentor drew the student's attention to unsatisfactory performance the student felt that the mentor had violated the contract (Figure 2). George (2009) noted that anger and frustration could then surface. Rodwell and Guylas (2013) reported that nurses are particularly prone to taking breaches of psychological contracts personally and St Pierre and Holmes (2010, p1169) recognised that nurses who feel they have been subjected to organisational injustice used, "*various means to punish the source of the injustice*". These studies offer possible explanations for some of the students' responses. Elements of transactional analysis, for example, communicating from a child ego

state and acting in the role of victim role, are also useful in interpreting this behaviour (Berne 1961, Karpman 2007).

The following actions need to be considered when assisting mentors in managing coercive students:

1. *Encourage students to reflect of their own level of engagement*

Student nurses who focus on their own needs, rather than the professional attributes that patients and healthcare services need, pose a, “*potential risk for unethical actions and behaviours towards patients*” (Alves 2012, p1). They can also cause significant difficulty for mentors. Student entitlement is, therefore, one element of university ethos which it may be appropriate to moderate for those studying health and social care disciplines. The current move towards focussing on healthcare students’ level of engagement in their programme (Austin 2013), rather than their expectations of the programme, might be of benefit to both patients and mentors.

2. *Assuage mentors’ guilt*

Mentors reported feeling particularly guilty when the student would be withdrawn from the programme as a result of failing in practice, and would not become a nurse. Under such circumstances the feelings mentors experienced seemed to have some similarities with those observed in middle-managers who had been required, by their superiors, to make employees redundant. Noer (2009) reported that those left behind suffered negative feelings which persisted and were not resolved without support, making the residual workforce less productive. This is analogous to the mentor/student situation in a fail and withdraw scenario. Students who fail are usually invested in post-failure by Universities and can become survivors, moving on to other courses of study, whilst mentors continue to experience negative emotions, because little is invested in their post failure needs.

It is suggested that human resource strategies (Heathfield 2014) can be applied to help mentors manage their guilt and reduce burn-out. One such strategy is demonstrated in Table 2. This present study demonstrates that when a supportive person undertook some or all of the activities noted in Table 2, mentors were better able to cope with the emotional burden which surrounds failing a student nurse.

3. *Alleviate mentors' fear*

A combination of psychological and physical threats generated fear in mentors. It was notable that some seemed to accept this level of threat as normal. This contributes another facet to the culture of fear identified as being prevalent in the NHS (Department of Health 2013). Mentors were better able to resolve their fear when support was available from administrative departments and official bodies that could help shield them from some of the personal risks they identified in failing a student; these are demonstrated in Figure 3.

Practice Education Facilitators, who participated in the study, recognised that they were best acquainted with these support structures, and could act as a conduit between the mentor and the appropriate sphere of support. Occupational health departments could provide stress management resources for mentors. Human resource departments could provide helpful advice when students claimed that they were the victims of discrimination, bullying or harassment by the mentor. It was noted that male mentors seemed more likely than their female counterparts to seek representation and support from professional bodies or trade unions. They were also much clearer than their female colleagues about the official procedures which existed to protect them. However, it was of concern that mentors of both genders were reluctant to call on security staff or the police when threats became physical. One explanation was that mentors were particularly keen to avoid negative publicity for their organisation. Another was that mentors accepted that they had to cope with such threats or risk being seen as incapable. Further investigation is recommended into this phenomenon.

Mentors were also reluctant to refer students to University fitness for practice processes when they made physical threats because they often mistrusted such processes feeling they were weighted in the students' favour. This view is supported by Simpson and Murr (2013) who suggested that universities take up a defensive position in such situations. Nevertheless, what became clear was that formal support was most effective when it originated from the top of the organisational hierarchy and permeated through all levels, this being equally relevant in both healthcare settings and in universities.

Recommendations

The recommendations this study makes are directed towards:

- professional regulatory bodies, particularly the NMC in the UK;
- university managers and programme leads;
- health care employers;
- those who support mentors in practice areas.

Four recommendations emerged from these findings (Figure 4):

1. ***Universities should manage students' expectations of mentors:*** Mentors need to be viewed, by students, as having equal status with academic assessors. This helps students to develop the same expectations of rigorous assessment in both practical and academic assessments, reducing automatic expectations of a pass being awarded in all practical placements. This adjusts the psychological contract between student and mentor. It is recommended that Universities include this in students' preparation for practice and placements.
2. ***Those who support mentors in practice should help them to recognise the locus of the fail:*** This provides a reality check, helping the mentor to appreciate it is the student's performance not theirs which is below the required standard. It stops the mentor blaming themselves for the student's underperformance and encourages

them to recognise that the student is responsible for their own actions. This helps to reduce mentor guilt.

3. ***Mentor preparation programmes and updates should educate mentors to recognise coercive strategies:*** The impact of the coercive strategies on mentors is reduced as soon as they recognise them. Mentors are then able to develop counter strategies to increase their resilience.
4. ***Employers and professional bodies must invest more in mentors' post-failure needs. Provision of appropriate support structures and agencies must be made apparent and mentors must be actively encouraged to access:***

Introducing social support mechanisms (Figure 3) for mentors reduces feelings of isolation, particularly when managing disparaging and aggressive students. It highlights that they should make use of official safeguards and protection against threats and emphasises that they are not expected to manage such situations on their own. Such support helps to reduce mentors' fear and guilt when they are being threatened by students.

Given the current emphasis in the literature on mentoring, the points raised in the study's findings (Hunt *et al.* 2016, p82) may be considered controversial and some nurses and nurse educators may find the idea very disturbing. Whilst this paper is not suggesting that all students are coercive, the profession cannot ignore the evidence provided in this study that some of them are. Whilst this is not acknowledged and discussed such behaviour can continue to flourish. There is a clear need for further research to be undertaken in this area, particularly around strategies to manage student behaviours and mechanisms to support mentors effectively. Something is clearly wrong with a mentoring system in which this happens far more often than has so far been acknowledged.

Limitations

This paper reports on one finding of a larger study. Coercive students were not the primary focus of this research and this issue deserves further focussed investigation. It is acknowledged that this study only sought the views of mentors, practice educators and link lecturers and that student's perspectives are not represented here. Wider claims outside the group who participated in the study are not made, but it is worth noting the strong resonance these findings have had with audiences during conference proceedings (Hunt 2016). This indicates that the findings of this study may be transferrable to other groups. Finally, the author acknowledges her background in practical assessment which may have some bearing on the interpretation of data provided by participants.

Conclusion

The evidence presented indicates that coercive students do exist and that they consciously and subconsciously seek to subvert practical assessment process, particularly when it is identified that they are failing. They use a variety of strategies to generate guilt and fear in mentors. Mentors need help to manage such feelings so that practical assessments can be conducted objectively. Strategies which help mentors include: managing students expectations of the practical assessment process and the mentor's role in this; developing strategies to help mentors recognise when the locus of the fail is with the student; provision of formal underwriting support for mentors in situations where official investigations are instigated against them; developing confidence to call on security and police services where physical threats are made and increasing courage to refer students through university fitness to practice panels in such circumstances. Practical assessments processes become more robust when mentors are supported to resist the coercive strategies underperforming students can employ. Progress towards this requires Universities and practice partners to actively work together to develop robust systems which invest in mentors' needs, both during

challenging practical placements and post failure, so that mentors and students are equally well supported.

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Table 1. The Role and Field of Nursing of Participants

	Adult	Child	Mental Health	Learning Disabilities	Total
Mentors	6	3	4	2	15
PEF	5	2	1	0	8
LL	6	1	1	0	8
Total	17	6	6	2	31

<u>Tips for Coping When You have Failed a Student</u>
Recognise that your emotions are legitimate
Experience and work through each phase of loss (Kubler-Ross 1969)
Seek advice from your Link Lecturer or Practice Education Facilitator
Recreate your daily working patterns
Treat yourself with kindness
Talk about your feelings
Pay attention to the student's needs
Value other students and mentors
If feelings of guilt persist seek professional help from(name/dept contacts)

Table 2. Managing Mentor's Guilt (adapted from Heathfield 2014)

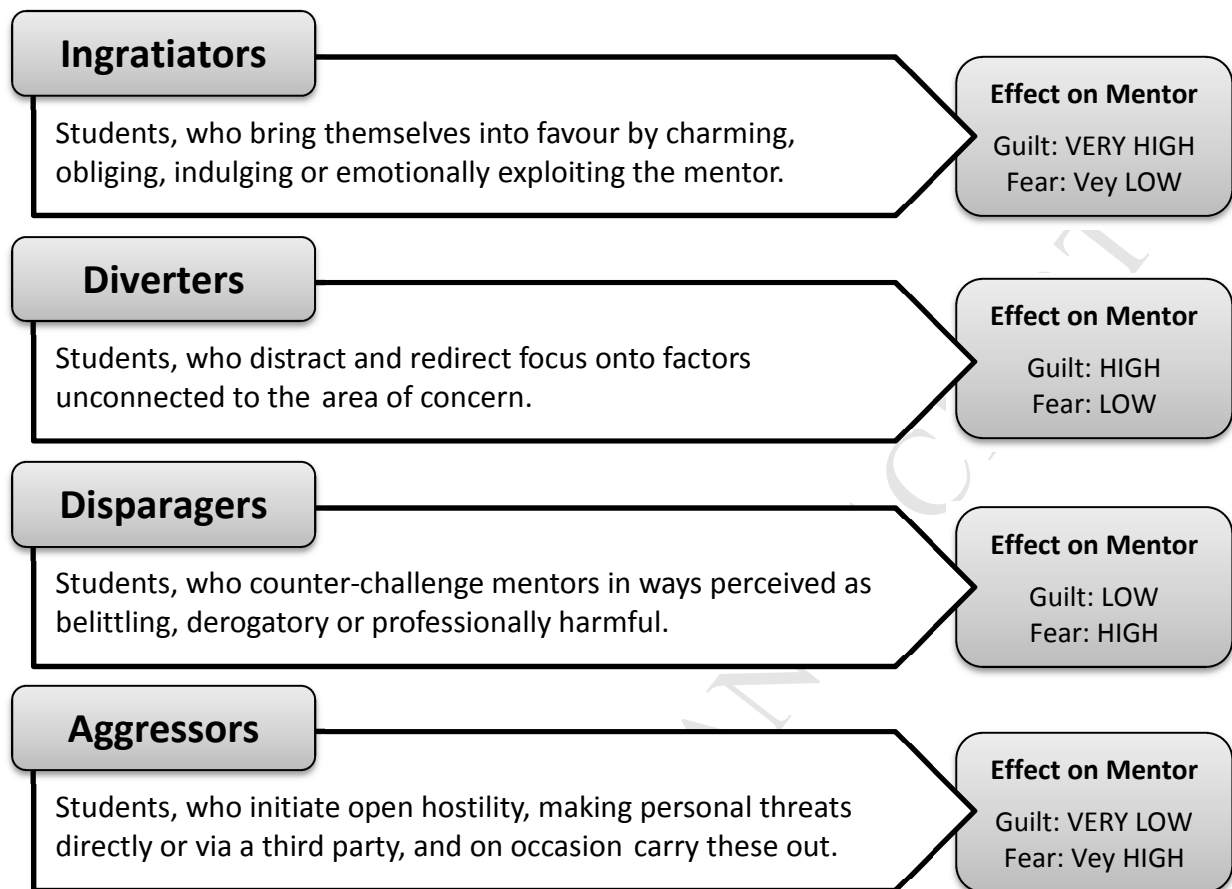
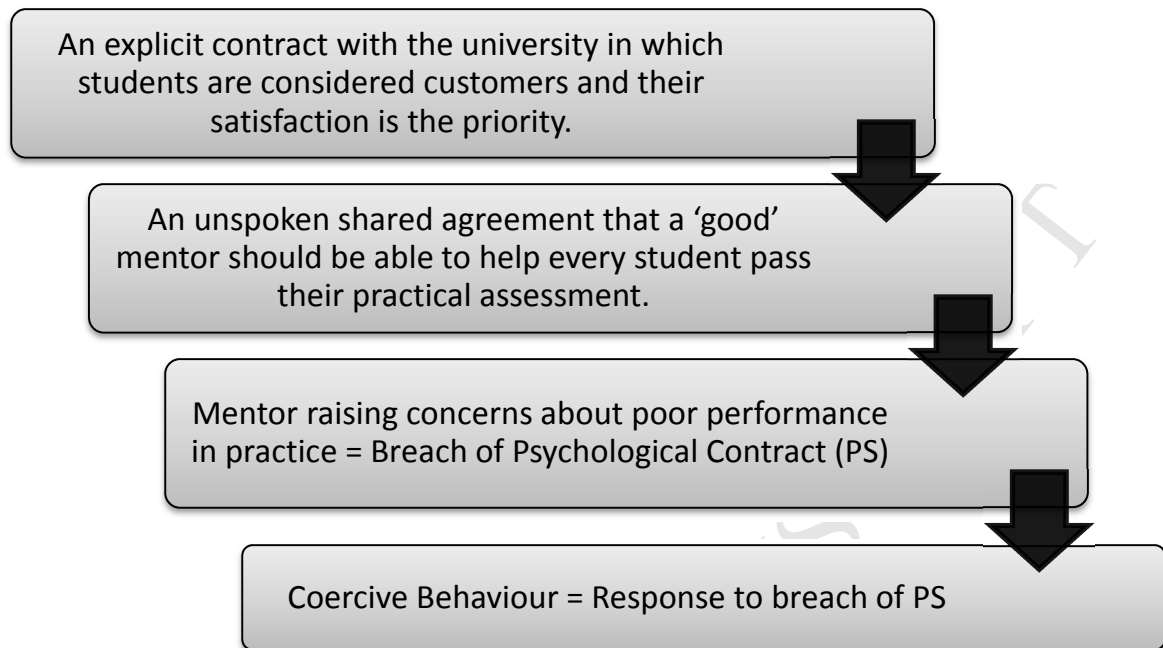
Figure 1. Types of Coercive Students and their Effect on Mentors

Figure 2 – The Perceived Psychological Contract between Student and Mentor

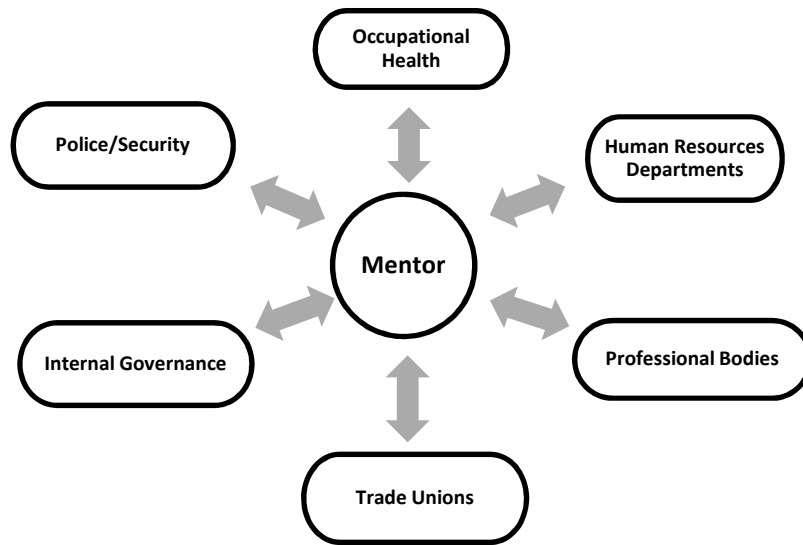


Figure 3. Sources of Underwriting Support

Figure 4. Recommendations

Action	Rationale
Manage students' expectations of mentors	Adjust the psychological contract so that: Students do not expect to automatically pass Mentors viewed as equal in status to academic assessors.
Enable mentors to recognise the locus of the fail	Helps mentor to understand it is the student whose performance is below the required standard. Reduces guilt. Provides a reality check.
Teach mentors to recognise coercive strategies	The efficacy of the coercive strategy is reduced as soon as the mentor recognises it. The mentor can then develop counter strategies to develop resilience.
Provide contact with appropriate support agencies	Introduces social support to help resist fear. Provides official safeguards and protection against threats (i.e. police, human resource departments, professional bodies or unions)

Conflict of Interest Statement

Dr. Louise Hunt is employed by Birmingham City University, Professor Paula McGee is a Professor Emerita of Birmingham City University, Dr Robin Gutteridge is employed by the University of Wolverhampton and Dr Malcolm Hughes was employed by Birmingham City University. Transcription and travel expenses were funded by Birmingham City University.